Georgia Department of Human Services

Georgia Senior Supplemental Nutrition Assistance Program (SNAP) Application

This application is used for individuals applying for the Supplemental Nutrition Assistance Program (SNAP) ***(****formerly the Food Stamp Program)*. The Georgia Senior SNAP program is an elderly simplified application project designed to make it easier for seniors to receive food stamp benefits.

To be eligible for the Senior SNAP program, everyone in the household must be:

- 60 years of age or older;
- must purchase and prepare their meals together;
  AND
- have no earnings from work.

You may file this application by completing your name and address, and by signing the form. If you need help filling out this application or assistance communicating with us, call us at 404-370-6236 or mail your application to Georgia Senior SNAP: P.O. Box 537, Avondale Estates, GA 30002. If you are deaf or hard of hearing, call GA Relay at 1-800-255-0135. Our services are free. If you are living in an institution and applying for Food Stamps (SNAP) and SSI at the same time, the filing date of your application is the date you are released from the institution.

Can I Choose Someone to Apply for SNAP for me?

Complete this section only if you want someone to fill out your application for you as your authorized representative.

Name: _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____

Tell us who you are and where you live. We must be able to reach you by telephone.

First Name	*Middle Initial*	*Last Name*	*Suffix*
Street Address Where You Live			*Apt*
City		*State*	*Zip Code*
Mailing Address (if different)			
City		*State*	*Zip Code*
Home Telephone Number	*Other Contact Number*		*E-Mail address*
For Office Use Only		Date Received By The County	

Do I Qualify to Get SNAP Benefits Faster?

Answer these questions about <u>the applicant and all household members</u> to see if you can get SNAP benefits within 7 days.

Did anyone in your household get money this month? ❑ Yes ❑ No If yes, how much? _____
When? _____

How much money do you and all household members have in cash or in the bank? $ _____

How much do you and all household members pay for rent or mortgage and all utilities (electric, gas, water, etc?

$

Tell us about the applicant and all household members. List yourself (or the person above shown on the first line).

NAME First Middle Initial Last	Relation-ship to You	Social Security Number (SSN) **(See statement below)**	Date of Birth	Sex (M/F)	Age	*** Optional		Are you a U.S citizen, qualified alien or in a satisfactory immigration status? (Y/N)
						Hispanic Yes /No	Race (See below)	
	SELF							

***** Penalty Warning:** Individuals who are applying for Food Stamps must provide or apply for an SSN as required by the Food and Nutrition Act of 2008. We will verify and use your SSN for Federal and State data matches, including but not limited to, Social Security, VA, GA Department of Labor, program disqualifications, and for collection of fraud debts. We will also match your information with other Federal, state, and local agencies to verify your income and eligibility. Collateral contacts will be used to verify information when discrepancies are found. If immigration status information has been submitted on your application, this information may be subject to verification through the United States Citizenship and Immigration Service (USCIS) and will require submission of certain information from this application to USCIS.
***** Optional:** We collect data on race color, and national origin to ensure we are in compliance with Federal civil rights laws. By providing this information, you will assist us in administering our programs in a non-discriminatory manner. Your household is not required to give us this information and it will not affect your eligibility or benefit level. **Choose one or more race codes**: **AL**-American Indian/Alaska Native; **AS**-Asian; **BL**-Black; or African American; **HP**-Hawaiian or other Pacific Islander; **WH**-White.

Tell us more about the applicant and all household members

1) Has anyone been convicted of a drug-related felony that was committed after 8/22/96? Yes ❑ No ❑

   If yes, name of person: _____

2) Is anyone in your household currently serving a Food stamp disqualification due to fraud? Yes ❑ No ❑

   If yes, name of person: _____

3) Has anyone been convicted of giving false information about where they live and who they are to get multiple food stamp benefits in more than one area after 8/22/96? Yes ❑ No ❑

   If yes, name of person:_____ when: _____ where:_____

4) Is anyone trying to avoid prosecution or jail for a felony? Yes ❑ No ❑

   If yes, who: _____

5) Is anyone violating conditions of probation or parole? Yes ❑ No ❑

   If yes, who: _____

6) Have you or any household member been convicted of trading Food Stamp benefits for drugs after 8/22/96?

   Yes ❑ No ❑

7) Have you or any household member been convicted of buying or selling Food Stamp benefits over $500 after 8/22/96? Yes ❑ No ❑

8) Have you or any household member been convicted of trading Food Stamp benefits for guns, ammunition or explosives after 8/22/96? Yes ❑ No ❑

Georgia Department of Human Services

Application for Benefits



Tell us about the income your household receives

Does anyone in your household receive money from social security, SSI, VA, retirement, or any other income?

Yes ☐ No ☐ **If yes, complete the chart below.**

Name	Source	Gross Monthly Amount (before taxes, deductions and Medicare premium)

Tell us about your shelter and utility expenses

	YES	NO	If YES, list monthly/yearly amount
Does your household pay mortgage?			
Does your household pay rent?			
Does your household pay property taxes on the home?			
Does your household pay homeowner's insurance?			**If YES, list monthly/yearly amount**
Does your household pay for heating or cooling costs?			
If your household does not pay heating or cooling costs, do you pay other utilities?			**If YES, list the utility costs you pay and the amount you pay below.**

Tell us about your medical expenses

Does your household pay out-of-pocket medical expenses over $35 per month? Yes ❑ No ❑

Do you pay a Medicare Premium? Yes ❑ No ❑

If yes, complete the chart below. We will need proof of your medical expenses. You may be potentially eligible to receive more benefits.

Person Who Has The Bill	Type of Expense (Doctor, Hospital, Prescriptions, Medicare Premium, transportation)	Amount Owed

Do you or someone in your household pay legally obligated child support to someone living outside of your home? Yes ☐ No ☐ If yes, who and how much per month? _____

For more information about TANF Community Outreach Services, please call 1-877-423-4746 or visit our website at: http://www.dfcs.dhr.georgia.gov.

Only US citizens and qualified aliens are eligible for SNAP benefits. Any non-citizens or non-qualified aliens may be left off your application for assistance. Such persons will not be reported to the Immigration and Customs Enforcement Agency. Non-citizens included on your application will have eligibility determined under the SNAP rules. The income and resources of all individuals in your household will be considered in determining eligibility for persons included on the SNAP application.

I certify that each applicant included in my household is a U.S. citizen or alien in lawful immigration status and that the information provided is true to the best of my knowledge. I give permission for the Georgia Department of Human Services to make a full review of my case and any necessary contacts to verify my statements. I know that I could be penalized if I knowingly give false information. I certify that I received the Rights and Responsibilities handout from this agency.

_____	_____	_____
Signature of Applicant	Date	Signature of witness if signed by mark
_____	_____	_____
Signature of Authorized Representative	Date	Signature of witness if signed by mark

SNAP PENALTY WARNINGS

You may lose your benefits or be subject to criminal prosecution for knowingly providing false information.

- Do not give false information or hide information to get benefits that your household should not get.
- Do not use Food Stamps or EBT cards that are not yours and do not let someone else use yours.
- Do not use Food benefits to buy nonfood items such as alcohol or cigarettes or to pay on credit cards.
- Do not trade or sell Food Stamps or EBT cards for illegal items; such as firearms, ammunition or controlled substance (illegal drugs).

Any household member who breaks any of the Senior SNAP (food stamp program) rules on purpose can be barred from the Food Stamp Program for one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. She/he may also be subject to prosecution under other applicable Federal and State laws. She/he may also be barred from the Food Stamp Program for an additional 18 months if court ordered.

Any household member who intentionally breaks the rules may not get Food Stamps for one year for the first offense, two years for the second offense, and permanently for the third offense.

If a court of law finds you or any household member guilty of using or receiving food stamp benefits in a transaction involving the sale of a controlled substance, you or that household member will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you or any household member guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, you or that household member will be permanently ineligible to participate in the Food Stamp Program upon the first offense of this violation.

If a court of law finds you or any household member guilty of having trafficked benefits for an aggregate amount of $500 or more, you or that household member will be permanently ineligible to participate in the Food Stamp Program upon the first offense of this violation.

If you or any household member is found to have given a fraudulent statement or representation with respect to identity (who they are) or place of residence (where they live) in order to receive multiple Food Stamp benefits, you or that household member will be ineligible to participate in the Food Stamp Program for a period of 10 years.

NON-DISCRIMINATION STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) **mail**: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) **fax**: (202) 690-7442; or

(3) **email:** program.intake@usda.gov.

This institution is an equal opportunity provider.

You may also file a complaint of discrimination by contacting **the DFCS Civil Rights Program**, Two Peachtree Street, N.W., Suite 19-248, Atlanta, Georgia 30303 or call (404) 657-3735 or fax (404) 463-3978. For limited English proficient and sensory impaired services, contact the DHS Limited English Proficiency and Sensory Impaired Program at: Two Peachtree Street, N.W., Suite 29-103 N.W., Atlanta, GA 30303 or call (404)-657-5244 or fax (404)-651-6815.

Under the Department of Community Health (DCH) policy, Medicaid cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or political or religious beliefs. To report Medicaid eligibility or provider discrimination, call the Georgia Department of Community Health's Office of Program Integrity (local 404-463-7590) (toll free) 800-533-0686.